Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS5391PCA		B. WING		07/	23/2009	
NAME OF PROVIDER OR SUPPLIER FAMILY FIRST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N RAINBOW STE 121 LAS VEGAS, NV 89107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
P 000	Surveyor: 27286 This findings and cor by the Health Divisio prohibiting any crimin actions or other claim available to any party state or local laws. This Statement of Dear result of the initial Sconducted in your ag State Licensure survauthority of NRS 449 Division. The agency has apple Personal Care Aide Ain-home personal cardisabled persons. The census at the tinclients. One mock client file of the property of the survailable of the consultation of the census at the tinclients.	nclusions of any investion shall not be construed all or civil investigations as for relief that may be younder applicable feder eficiencies was generate State Licensure survey gency on July 23, 2009. ey was conducted by the 150, Powers of the Healied for a license as a Agency which provides are services to elderly arme of the survey was zewas reviewed and one reviewed along with the Fual.	d as s, ral, ed as This ae alth	P 000				
P 140 SS=A	Section 15(5) Infection 5. Provide for the pre-		е	P 140				
	Surveyor: 27286 Based on record revi	not met as evidenced be iew, the agency did not r the investigation of						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 11/12/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5391PCA 07/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 N RAINBOW STE 121 **FAMILY FIRST HOME CARE** LAS VEGAS, NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 140 Continued From page 1 P 140 infections and communicable diseases. Findings include: The agency policy and procedure manual was reviewed. The policy or procedure lacked documented evidence describing how the agency would investigate infections and communicable diseases. Severity: 1 Scope: 1 P 160 P 160 Section 15(7) Attendant Assignment/Supervision SS=A 7. Provide a description of the manner in which the agency assigns attendants to provide personal care services to clients and any supervision of those services that will be provided the agency; This STANDARD is not met as evidenced by: Surveyor: 27286 Based on record review and interview, the agency's policies and procedures failed to provide a description of the manner in which it assigns attendants to provide services.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Findings include:

The agency policy and procedure manual was reviewed. The policy or procedure lacked documented evidence of a description of how the agency assigns attendants to provide services to clients. The administrator was interviewed and provided a verbal description of how assignments are made, but it wasn't in the policy manual.

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		NVS5391PCA		B. WING		07/23	3/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
FAMILY FIRST HOME CARE			800 N RAIN LAS VEGAS	BOW STE 12 5, NV 89107	1		
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P 160	Continued From page 2			P 160			
	Severity: 1 Sco	рре: 1					
P 170 SS=A	Section 15(8) Docume	entation of Care		P 170			
	8. Provide for documentation of the needs of each client and the personal care services that are provided to the client;		f				
	This STANDARD is not met as evidenced by: Surveyor: 27286 Based on record review and interview, the agency's policy and procedure manual lacked a description of the manner in which it provides for the documentation of the needs of each client and the personal care services that are provided to the client.		ed a s for nt				
	Findings include:						
	reviewed. The policy documented evidence agency would documented to the client. The adnand provided a description.	or procedure manual variety or procedure lacked or procedure lacked or of a description of howent the needs of each of exercises that are proveninistrator was interviewed in the care plants wasn't in the policy and	w the client ided wed and				
	Severity: 1 Sco	ppe: 1					
P 200 SS=A	Section 15(11 Perform	mance Evaluation		P 200			
	11. Provide for period performance of attend of the staff of the age	dants and other member	ers				

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING

B. WING __ NVS5391PCA 07/23/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FAMILY F	IRST HOME CARE	800 N RAINBOW STE 121 LAS VEGAS, NV 89107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
P 200	Continued From page 3		P 200				
	This STANDARD is not met as evidenced by Surveyor: 27286 Based on record review, the agency failed to have a policy providing for periodic performations of staff.	0					
	Findings include: The agency policy and procedure manual was reviewed. The policy or procedure lacked documented evidence which provided for periodic evaluations of attendants and other staff members of the agency.						
	Severity: 1 Scope: 1						
P 210 SS=A			P 210				
	This STANDARD is not met as evidenced be Surveyor: 27286 Based on record review, the agency failed to have a policy providing for the maintenance current personnel records which confirm that policies and procedures are being followed.	o of it the					
	Findings include:						
	The agency policy and procedure manual w reviewed. The policy or procedure lacked documented evidence which confirmed how agency would maintain the personnel record show that the policies and procedures were	the ds to					

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PRINTED: 11/12/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5391PCA 07/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 N RAINBOW STE 121 **FAMILY FIRST HOME CARE** LAS VEGAS. NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) P 210 Continued From page 4 P 210 followed. Severity: 1 Scope: 1 P 320 P 320 Section 19.1(c) Training SS=A Sec. 19. 1. Each attendant of an agency shall: (c) Receive training: (1) In the written documentation of: (I) Personal care services provided to the clients of the agency; and (II) Verification of time records. (2) In the rights of clients, including, without limitation, training in methods to protect client confidentiality pursuant to state and federal regulations. (3) Related to the special needs of elderly persons and persons with disabilities. including, without limitation, training in the sensory, physical and cognitive changes related to the aging process. (4) Related to communication skills, including, without limitation, active listening, problem solving, conflict resolution and techniques for communicating through alternative modes with persons with communication or sensory impairments.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This STANDARD is not met as evidenced by:

Based on record review, the agency failed to provide a training syllabus to show how the Personal Care Attendants were to be trained

Scope: 1

Surveyor: 27286

Severity: 1

before caring for clients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS5391PCA		NVS5391PCA		B. WING		07/2	3/2009
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
FAMILY F	FAMILY FIRST HOME CARE			OW STE 12 ⁻ NV 89107	1		
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P 340	Continued From page	e 5		P 340			
P 340 SS=A	Section 19.1(c)(6)(I-II	I) Training		P 340			
	Section 19.1(c)(6)(I-III) Training Sec. 19. 1. Each attendant of an agency shall: (c) Receive training: (6) That is specifically related to the personal care services provided by the agency, including, as applicable, training in the following topics: (I) Duties and responsibilities of attendants and the appropriate techniques for providing personal care services; (II) Recognizing and responding to emergencies, including, without limitation, fires and medical emergencies; (III) Dealing with adverse behaviors; This STANDARD is not met as evidenced by: Surveyor: 27286 Based on record review, the agency failed to provide a training syllabus to show how the Personal Care Attendants were to be trained before caring for clients. Severity: 1 Scope: 1		l ving and cies, al				
P 350 SS=A	Section 19.1(c)(6)(IV)	-		P 350			
	Sec. 19. 1. Each attendant of an agency shall: (c) Receive training: (6) That is specifically related to the personal care services provided by the agency, including, as applicable, training in the following topics: (IV) Nutrition and hydration, including, without limitation, special diets and meal preparation and service; This STANDARD is not met as evidenced by:		l ling, : ut				
	Surveyor: 27286	iot mot do ovidended b	,.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER	NVS5391PCA	STREET ADDR	RESS. CITY. STA	TE. ZIP CODE	07/23/2009			
EAMILY EIRST HOME CARE			800 N RAIN	ADDRESS, CITY, STATE, ZIP CODE LAINBOW STE 121 GAS, NV 89107					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE			
P 350	provide a training syll Personal Care Attend before caring for clien	ew, the agency failed to labus to show how the dants were to be trained		P 350					
P 360 SS=A			all: ving ut are of the	P 360					
	This STANDARD is not met as evidenced by: Surveyor: 27286 Based on record review, the agency failed to provide a training syllabus to show how the Personal Care Attendants were to be trained before caring for clients. Severity: 1 Scope: 1)						
P 370 SS=A	Section 19.1(c)(6)(VI	-VII) Training Skin		P 370					

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Sec. 19. 1. Each attendant of an agency shall:

(6) That is specifically related to the personal care services provided by the agency,

(VIII) Hand washing and infection control;

including, as applicable, training in the following

This STANDARD is not met as evidenced by:

(c) Receive training:

topics:

SS=A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	COMPLET			
		NVS5391PCA				07/2	23/2009	
FAMILY FIRST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 800 N RAINBOW STE 121 LAS VEGAS, NV 89107					
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P 380	Surveyor: 27286 Based on record rev provide a training syl Personal Care Atten- before caring for clie	iew, the agency failed to llabus to show how the dants were to be trained		P 380				
P 390 SS=A	Sec. 19. 1. Each atte (c) Receive training: (6) That is specificall care services provide including, as applica topics: (IX) Body mechanics techniques, including simple nonprescribed This STANDARD is Surveyor: 27286 Based on record rev provide a training syl	ble, training in the follows, mobility and transfer	all: ving y:	P 390				
P 400 SS=A	Section 19.1(c)(6)(X) Sec. 19. 1. Each atte (c) Receive training: (6) That is specificall care services provide	cope: 1 Training Safe Environrendant of an agency share y related to the persona	all:	P 400				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		NVS5391PCA		B. WING		07/2	3/2009	
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NAME OF PR	OVIDER OR SUPPLIER							
FAMILY F	FAMILY FIRST HOME CARE			IBOW STE 12 S, NV 89107	1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
P 400	Surveyor: 27286 Based on record reviprovide a training syl Personal Care Attendates before caring for clie	not met as evidenced be ew, the agency failed to labus to show how the dants were to be trained)	P 400				
P 430 SS=A	2. The written disclose a description of and is concerning the personal the agency, including (a) A statement which the client indicating the scope of the licer the medical and heal should the conditions unpredictable; (b) The qualifications for the attendants who care services to the concerning to the conditions of the attendants who care services to the condition of the condi	sure statement must inconformation onal care services offered g, without limitation: h is easily understandal hat it is not within hase of the agency to ma th conditions of clients is become unstable or and training requirement to provide personal clients of the agency; he personal care service her; iilling methods, payment for bills for personal care cy for notifying clients of s of personal care services	ed by ble to anage ents t es f cces	P 430				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS5391PCA		B. WING		0.7	/23/2009
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FAMILY FIRST HOME CARE				BOW STE 12 S, NV 89107	1		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
P 430	policy for notifying clipersonal care service (f) Procedures for conthe agency or his deshours in which person provided and the oneony of the grievance progency. This STANDARD is Surveyor: 27286 Based on record revision of the agency's Disclor following required discussions (d) A description of both systems, due dates for services and the politincreases in the cost provided by the agents.	ents of such termination es; ntacting the administrat signee during all nal care services are call policy of the agency erning the rights of clien ocedure of the not met as evidenced be ew, the agency's Discle ontain all of the required sclosure information: iilling methods, payment for bills for personal care cy for notifying clients of s of personal care servi	or of y; and tts y: osure d the t	P 430			
P 500 SS=A	3. The agency shall of before providing the services outlined in the for the client and as of service plan is revised (a) Evaluate whether	he service plan establis often as necessary if the	asks hed e	P 500			

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Findings include:

The Disclosure Statement was reviewed and there lacked direction stating what the client

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5391PCA 07/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 N RAINBOW STE 121 **FAMILY FIRST HOME CARE** LAS VEGAS, NV 89107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) P 500 Continued From page 12 P 500 should do if an attendant did not appear for a scheduled visit, or if an additional visit from an attendant was required. Severity: 1 Scope: 1

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.